

# Exhibit C

STORAGE NAME: s1000z.hc

DATE: May 21, 1991

\*\*AS PASSED BY THE LEGISLATURE\*\*  
CHAPTER #: 91-282, Laws of FloridaHOUSE OF REPRESENTATIVES  
COMMITTEE ON  
HEALTH CARE

## FINAL BILL ANALYSIS &amp; ECONOMIC IMPACT STATEMENT

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BILL #: CS/CS/SB 1000

RELATING TO: Health Care Facilities &amp; Services

SPONSOR(S): Committees on Finance, Taxation and Claims and Health and  
Rehabilitative Services and Senators Malchon, Kirkpatrick and  
Forman

STATUTE(S) AFFECTED: ss. 11.45, 20.055, 110.123, 154.01, 154.011, 186.003, 186.022, 186.503, 186.507, 186.508, 186.511, 187.201, 216.176, 216.136, 381.025, 381.701-381.715, 381.703, 381.706, 381.708, 381.713, 383.14, 383.011, 383.013, 383.215, 383.216, 383.2161, 390.014, 394.4787, 395.004, 395.007, 395.01465, 395.0335, 395.034, 395.0345, 400.062, 400.126, 400.18, 400.23, 400.332, 400.407, 400.418, 400.467, 400.605, 401.291, 407.50, 407.51, 409.266, 409.2662, 409.2663, 409.2666, 409.2667, 409.267, 409.2671, 409.2673, 409.268, 409.345, 409.701, 409.901 - 409.920, 409.2665, 410.306, 427.012, 483.172, 383.703, 401.291, 381.025, 624.424, 627.4106, 627.736, 631.813, 641.261, 641.31, 641.311, 641.411, 641.48, 641.495, 641.51, 641.511, 641.512, 641.515, 641.52, 655.50, 768.73, 895.02, 895.02, 896.101, Florida Statutes

COMPANION BILL(S): HB 735, CS/CS/HB 1161, CS/CS/HB 1169, CS/HB 1215, CS/HB 1529, CS/CS/HB 1771, CS/HB 2445, HB 2559

## COMMITTEES OF REFERENCE:

- (1) HEALTH AND REHABILITATIVE SERVICES
- (2) FINANCE, TAXATION AND CLAIMS
- (3) APPROPRIATIONS
- (4)
- (5)

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I. SUMMARY:

This is an omnibus health care bill which includes the following: an increase in health facility fees and certificate of need fees to make that regulatory program self funding; revisions to the CON law; revisions used by the Auditor General in conducting performance audits; a "truth in budgeting" provision to be included in the Governor's proposed budget recommendations; an expansion of the duties of the Revenue Estimating Conference to include trust funds; a "healthy start" program to reduce Florida's infant mortality rate; a comprehensive rewrite of the statute which creates the state's Medicaid program; revisions to the trauma program; a Sunset Review of Part IV of Chapter 641, F.S., which relates to quality of care in health maintenance organizations; the creation of a health care purchasing cooperative for state and local governments; revisions to the health planning statutes to establish a clear relationship between health planning and the state comprehensive planning process; revisions to a training requirement necessary to use a defibrillator; small group health insurance rating reforms; and the creation of a health care work group to make recommendations to the Governor and the Legislature on health care reforms. A lengthy fiscal note is attached.

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## II. SUBSTANTIVE ANALYSIS:

### A. PRESENT SITUATION:

#### Health Facility Fee Increases and Certificate of Need Revisions

The HRS Office of Regulation and Health Facilities administers the state health planning program, the certificate of need program, and the licensure program for health facilities and certain health personnel. Currently, the office is funded by a combination of general revenue (28 percent), federal funds (33 percent), and user fees in the form of license and inspection fees (39 percent). Health facilities are also assessed a health planning fee to cover the cost of the local and Statewide Health Council.

The certificate of need law requires that in order to initiate certain health related projects, such as the construction of a hospital or nursing home, or offering a new institutional health service, a CON must be obtained. However, there are exemptions contained in the law for certain projects undertaken by an HMO and for projects funded by the Legislature.

#### Auditor General

Section 11.45, F.S., 1990 Supplement, authorizes the Auditor General to conduct financial and performance audits of various state and local agencies. Section 11.45(7)(e), F.S., 1990 Supplement, requires each agency which has been audited to give the Legislative Auditing Committee a written explanation of the status of the Auditor General's recommendations. This explanation is to be submitted six months after the published date of an audit report.

Section 20.055, F.S., 1990 Supplement, requires the head of each state agency, including the state courts system, to appoint a chief internal auditor. The chief internal auditor is required to review and evaluate the agency's internal controls necessary to ensure the fiscal accountability of the state agency, as well as to conduct financial, compliance, and performance audits. As currently written, neither s. 11.45 nor 20.055, F.S., 1990 Supplement, specify the role of the chief internal auditor in providing a written status report of the agency's response to the Auditor General's recommendations.

Performance audits examine the effectiveness of administration and the efficiency and adequacy of a governmental program. Section 11.45(3)(a)2., F.S., 1990 Supplement, authorizes the Auditor General to make performance audits of all governmental entities created pursuant to law. Section 11.45(3)(a)3.a., F.S., 1990 Supplement, requires the Auditor General to conduct a performance audit of certain new major programs or modifications of major programs. Although professional standards and the Auditor General's practice dictate what is to be used as criteria for agency performance in conducting performance audits, current law

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does not specify which criteria the Auditor General is to use in measuring agency performance.

#### Truth in Budgeting

At least 45 days before the scheduled annual legislative session in each odd-numbered year, the Governor provides the Legislature with a copy of his recommended balanced budget for the state, based on his own conclusions and judgment. Included in this document are the details of his recommended balanced budget, including his recommended appropriations, revenues and a financial schedule showing that his estimates of state revenues will be sufficient to fund his recommendations.

#### Revenue Estimating Conference

The Revenue Estimating Conference is one of seven official state conferences. They are: the Economic Estimating Conference, the Demographic Estimating Conference, the Revenue Estimating Conference, the Education Estimating Conference, the Criminal Justice Estimating Conference, the Social Services Estimating Conference, and the Transportation Estimating Conference. The Revenue Estimating Conference, along with the other estimating conferences, develops official information, i.e., data, forecasts, estimates, analyses, studies, and other information which the principals of the estimating conference unanimously adopt for purposes of the state planning and budgeting system.

#### Healthy Start

While a number of maternal and infant health care programs exist in Florida, there is no systematic approach to screening for or providing accessible and comprehensive services to high-risk pregnant women and their children.

Section 383.013, F.S., requires the Department of Health and Rehabilitative Services to provide a statewide prenatal care program for low-income pregnant women. This law also requires that the availability and accessibility of prenatal services be monitored and special outreach programs be developed for medically underserved and for rural areas. The department currently services approximately one-third or 65,000 women of childbearing age. However, the HRS Family Health Services Unit indicates that enhanced services such as screening and risk assessment, outreach, case management and home visitation, psycho-social counseling, transportation, nutritional services or parenting and health education, are minimal due to a lack of resources.

Currently, pregnant women and families with incomes below 150% of the federal poverty level qualify for Medicaid services. The department estimates that 69,433 women meet this income eligibility level. With a participation rate in the Medicaid program of 79.7%, and an uninsured rate of 51.0%, the department is serving approximately 28,222 women or nearly one-third of the childbearing population. Medicaid reimbursement rates for pregnant women are currently at 150% of the federal poverty level.

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### Medicaid Statute Revision

The Medicaid program was created in 1965 as Title XIX of the Social Security Act. Its purpose was to help low-income and disabled persons meet the costs of necessary medical care. The Medicaid program was implemented in Florida on January 1, 1970.

Today, Medicaid is the largest health care insurer in the State of Florida. With a budget approaching \$3.3 billion, Medicaid is expected to serve 882,285 medically indigent persons in 1990-91. Funding for Medicaid is shared between the federal (54.5%) and the state (45.5%) governments.

The authority for state administration of the Medicaid program is found in section 409.266(1), F.S., which designates the Department of Health and Rehabilitative Services as the state agency responsible for the administration of Medicaid funds under Title XIX. The rest of section 409.266, F.S., is a patchwork of Medicaid provisions that is neither cohesive nor complete.

Regulations regarding program eligibility and services are not found in their entirety in the Florida Statutes, but they are found in the Social Security Act, the Code of Federal Regulations and in the State Plan that is required by the federal government. In recent years, the Florida Medicaid program has spent considerable time and effort in litigation defending its authority to implement policies, procedures, and payment rates without a solid basis in Florida Statutes.

### Trauma

Florida continues to be without an adequate trauma care system for the state. The number of trauma centers declined from 33 state verified trauma centers in 1986 to 13 in 1990. Two of the major reasons cited for the decline in trauma centers have been the lack of adequate compensation for trauma care and the rigorous verification standards.

In the 1990 Session, the Legislature established a new process for hospitals to become trauma centers and appropriated \$24 million to fund state-sponsored trauma centers and air ambulances in underserved areas.

The department began the process for selecting state-sponsored trauma centers and received from hospitals around the state 51 letters of intent to apply for the state-sponsored trauma center program.

State budget reductions that resulted from shortfalls in general revenue first reduced, then eliminated, the funding of the state sponsored trauma center program for fiscal year 1990-91. The department reports the number of hospitals that will submit their applications to become state-sponsored trauma centers by the April 1, 1991, deadline has dropped substantially due to the lack of funding.

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Additionally, last year's legislation replaced the process for becoming a verified trauma center with the state sponsorship process which anticipates funding. As they appear now, the statutes do not include provisions for verified trauma centers that are not state funded.

#### Sunset Review of Chapter 641, Part IV, HMOs

Complaints against HMOs in Florida began in the 1980s. Most were related to questionable enrollment practices and inadequate quality of care in those HMOs that held Medicare contracts with the federal government.

Chapter 641, Part IV, F.S., was added in 1987 to ensure that HMOs and prepaid health clinics delivered high-quality health care to their subscribers. This part requires an HMO to receive from the Department of Health and Rehabilitative Services a Health Care Provider Certificate which confirms that it is in compliance with the provisions of Part IV before it obtains from the Department of Insurance a Certificate of Authority to operate as an HMO in the state.

The Department of Health and Rehabilitative Services reports that, in general, the quality assurance programs of the HMOs in Florida have been found to meet the statutory requirements for quality assurance programs. However, complaints against HMOs continue. There is evidence of under-reporting of grievances by certain HMOs to the Department of Insurance.

The federal government has begun a series of investigations into the practices of seven HMOs in Florida that serve Medicare beneficiaries in addition to the general population.

#### Health Care Purchasing Cooperative

State government spending for health care services is rapidly escalating and takes a greater portion of the state budget each year. For example, the Medicaid budget alone constitutes over 12 percent of the state budget and Medicaid expenditures have been doubling every three years.

Spending for state employee health benefits has also been increasing rapidly, and the trust fund used to pay for employee health benefits has faced a deficit for each of the past several years. Benefits have been reduced and copayments and deductibles increased, and employee contributions have been increased in order to keep this fund solvent.

In total, state and local government health care spending increased from \$4.8 billion in fy 1988-89 to \$5.8 billion in fy 1989-90, an increase of 20.8 percent. This type of annual increase in health care spending is typical and represents a significant problem for state and local governments in this time of limited public resources.

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The Legislature, in an effort to curb the rapid escalation in health care spending, directed the Health Care Cost Containment Board to conduct a study on pooling of state and local government purchasing of health care (see section 25 of ch. 90-295, Laws of Florida). A technical assistance panel was convened by the board and a study was conducted. The recommendations of this study are embodied in SB 1000.

### Health Planning

Chapters 186 and 187, F.S., establish the structure and process for comprehensive planning by governmental entities in Florida. Sections 381.025 and 381.703, F.S., establish a separate structure and process for comprehensive health planning through the Department of Health and Rehabilitative Services.

Chapter 186, F.S., establishes a state and regional comprehensive planning structure and process. The Executive Office of the Governor is required to prepare a proposed state comprehensive plan providing long-range guidance for the orderly social, economic, and physical growth of the state. The state comprehensive plan may include goals and policies relating to health concerns. The current State Comprehensive Plan, section 187.201, F.S., 1990 Supplement, was developed in 1984, reviewed by the Administration Commission in early 1985, and adopted by the Legislature in 1985. Subsection (6) of s. 187.201, F.S., 1990 Supplement, contains the health element of the State Comprehensive Plan, although there are also health policies contained in other elements of the plan.

Chapter 186, F.S., also provides for the establishment of regional planning councils and comprehensive regional policy plans. The comprehensive regional policy plans must contain regional goals and policies which are consistent with and further the implementation of the goals and policies in the State Comprehensive Plan. Although there is a health element in the State Comprehensive Plan and comprehensive regional policy plans do address health, health planning has been a low priority for regional planning councils.

Section 381.703, F.S., establishes a system for comprehensive health planning consisting of eleven local health councils, the Statewide Health Council and the Department of Health and Rehabilitative Services. The local health councils are required to develop health plans for their districts. The department is also required to develop a state health plan, which is not defined in statute. There is no direct relationship between these plans and the health elements of the state, regional, and local comprehensive plans. However, the local health councils are supposed to advise and assist regional planning councils and local governments in the development of optional plan elements to address the health goals and policies in the State Comprehensive Plan. The Statewide Health Council also assists the Department of Community Affairs in reviewing local government comprehensive plans to ensure consistency with policies developed in the local health council plans.

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Section 381.025, F.S., requires the department to conduct long-range planning to establish a state policy framework for health care and services. Much of the specific requirements of this section relate to the department's public health programs. The department has interpreted this section as not requiring another state health plan separate from the state health plan required in s. 381.703(4), F.S., but the relationship between these two sections of statute is not clear.

#### Defibrillator

Section 401.291, F.S., 1990 Supplement, provides for the use of an automatic or semiautomatic defibrillator (AED) by individuals who meet a basic level of training. The training requirements are set forth in the bill and consist of certification in cardiopulmonary resuscitation or an 8 hour basic first aid course which includes cardiopulmonary resuscitation training, demonstrated proficiency in the use of an AED, and successful completion of at least 6 hours of training in the use of an AED. An AED may only be used by a trained individual if authorized by an emergency medical services medical director. In addition, an EMS medical director may authorize any physician to approve a properly trained individual to use an AED.

#### Small Group Health Insurance Rating Reforms

Currently, it is common practice for some insurers to price new business at very low levels and then to increase renewal rates dramatically as the impact of the initial underwriting and pre-existing condition exclusions wear off. This approach appears to segment the business into small pools based on the duration of risk and health status of the participants and does not spread the risk in the same way as with larger groups. It is believed by the department that this practice prevents a number of insurers from entering the small business marketplace since they cannot compete with the low initial pricing, yet may be better able to maintain the business at a reasonable level without extraordinary increases.

Sections 627.410 and 627.411, F.S., set forth the current rate filing requirements and procedures for approval. An insurer is prohibited from delivering or issuing for delivery or renewal in Florida any health insurance policy form until it has been filed with the department with a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule or any applicable premium rate or change in applicable premium rates. For approval of rates, the insurer must demonstrate the reasonableness of benefits in relation to premium rates. The department must disapprove a health insurance form: (1) if the benefits are unreasonable in relation to the premium charges; (2) if it contains provisions which are unfair or inequitable or contrary to public policy in Florida; or (3) which encourage misrepresentation. In determining whether benefits are reasonable in relation to premium charges the department must consider: (a) past loss experience and prospective loss

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experience within and without the state; (b) allocation of expenses; (c) risk and contingency margins, along with justification of such margins; and (d) acquisition costs.

Prior to solicitation in Florida, group health insurance policies issued or delivered outside of Florida (to an employer trust, for example) under which a resident of Florida (employee) is provided coverage must be filed for informational purposes with the department. Certain requirements apply, but there is no rate approval process currently required for these policies.

#### B. EFFECT OF PROPOSED CHANGES:

##### Health Facility Fee Increases and Certificate of Need Revisions

This section of the bill repeals exemptions to the CON law for projects funded and mandated by the Legislature currently contained in s. 381.706(3)(a), F.S. In addition, this portion of the bill repeals the exemption from the CON law relating to an HMO as specified in s. 381.713(1), F.S. Also included in this part is an increase in licensure, inspection, health planning and CON fees for health facilities:

##### Auditor General

This section specifies the criteria the Auditor General shall use in conducting performance audits and the role of agency chief internal auditors in responding to the Auditor General's audits of an agency.

A new section 11.45(3)(a)7., F.S., is created to specify that, while conducting performance audits, the Auditor General shall use an agency's Agency Functional Plan to measure the agency's performance.

A new section 20.055(8), F.S., 1990 Supplement, is created to require an agency's chief internal auditor to monitor the implementation of the agency's response to an Auditor General's audit of that agency. The chief internal auditor also is required to report to the agency head, no later than six months after the Auditor General publishes his audit of the agency, the status of corrective actions taken by the agency to address the Auditor General's recommendations.

##### Truth in Budgeting

This section establishes "Truth in Budgeting" and requires that the Governor's recommended budget must summarize all estimated fees, taxes, revenues, or other income which need to be raised to fund the proposed budget and its annualized costs. A similar statement must be prepared for the General Appropriations Act no less than 72 hours before the Governor's veto message is due.

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### Revenue Estimating Conference

This section expands the duties of the Revenue Estimating Conference to include trust fund review and estimating. In addition, it provides statutory authority for any principal of the Revenue Estimating Conference to review and estimate revenues for any trust fund.

### Healthy Start

The section establishes a Florida "Healthy Start" program which provides:

- enhanced prenatal and postpartum care to 20,662 high risk pregnant women and 8,611 high risk infants;
- expanded Medicaid coverage to 22,829 pregnant women and their children under age one;
- four prenatal and infant health care community-based coalitions;
- specialized high risk prenatal and obstetric care in twelve Regional Perinatal Intensive Care Center satellite clinics;
- pediatric primary care services to an additional 6,800 non-Medicaid eligible children;
- evaluation services for 11,000 infants and toddlers, intervention services for 4,906 newborns, and post discharge intervention services for 6,050 infants

### Medicaid Statute Revision

The bill codifies the Florida Medicaid program in statute. In doing so, it provides a comprehensive description of the program which is expected to improve the general understanding of Medicaid and its requirements. The bill confirms the department's authority to administer the Medicaid program and to develop policies, procedures and rules accordingly.

### Trauma

The section provides a mechanism for hospitals to become trauma centers when state funding is not available. In the event state funding becomes available, clarifications to claims submission and processing are provided which should facilitate payment to state-sponsored trauma centers.

### Sunset Review of Chapter 641, Part IV, HMOs

By requiring all HMOs to become accredited, the bill should provide greater assurance that all HMOs doing business in Florida meet nationally recognized standards of care.

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In addition, the bill should strengthen the Department of Health and Rehabilitative Services' ability to ensure the quality of health services provided by HMOs by giving it: 1) access to accreditation and external quality assurance review reports, 2) follow-up responsibilities, 3) access to medical records, and 4) the ability to sanction HMOs that are not in compliance.

#### Health Care Purchasing Cooperative

This part will establish the Florida Health Care Purchasing Cooperative. The cooperative is a nonprofit, private corporation organized pursuant to chapter 617, F.S. It would be created for the purpose of collecting data on the cost and utilization of health care services by cooperative members. This data would be analyzed by the cooperative in order to identify the most efficient health care providers and to make this known to the other members of the cooperative. All data of a confidential nature is protected from public disclosure and is exempt from the provisions of s. 119.07(1), F.S. This exemption is subject to the Open Government Sunset Review Act.

In addition to collecting data and identifying efficient providers, the cooperative is authorized to negotiate and enter into contract on behalf of cooperative members with health care providers and health care insurers. The cooperative may also contract directly with health care providers for the provision of health care services.

The section establishes a board of directors for the cooperative to include: the director of the Division of the State Employees Insurance of the Department of Administration; the Assistant Secretary for Medicaid of the Department of Health and Rehabilitative Services; the Assistant Secretary for Health of the Department of Corrections; two persons who are responsible for purchasing health benefits for municipal employees, appointed by the League of Cities; a person who purchases health care on behalf of a county, to be appointed by the Florida Association of Counties; and a person who purchases health care services for a school district, to be appointed by the Florida Association of School Administrators. All appointments must be made by August 1, 1991 and are for a two year period. Members may be reappointed. Board members are required to adopt bylaws for the corporation and are entitled to reimbursement for actual and necessary expenses incurred by them as members, according to state travel and per diem limitations. An exemption from liability is provided for board members while exercising their duties and powers under this act.

The section directs the Health Care Cost Containment Board to provide staff and administrative support to the cooperative until such time as the board of directors has organized itself and appointed an executive director. A first meeting of the board must be conducted on or before September 1, 1991.

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### Health Planning

This section establishes a clear relationship between the state comprehensive planning process and the comprehensive health planning process. Responsibilities of the various planning entities are defined in order to ensure compatibility among the health plans developed by various levels of government within the state.

### Defibrillator

This section repeals the current 8-hour basic first-aid training requirement and retains all other certification requirements pertaining to the use of an AED.

### Small Group Health Insurance Rating Reforms

This section limits the amount by which an insurer who provides coverage to small employers may increase rates for the small employer groups. It is intended to promote the availability of health insurance coverage to small employers by improving the efficiency and fairness in the small group market which in turn should entice more insurers into this market. Regulations are specified which should help to prevent abusive rating practices and require disclosure of rating practices to the purchaser of the insurance product. By limiting abuses and limiting cancellations, it is hoped that this section will help to provide continuity of coverage to small employers purchasing insurance.

This section applies to any health benefit plan provided by a small employer carrier which provides coverage to one or more employees of a small employer, except non-group health insurance policies which are subject to the form and rate review of the department.

Small employer carriers that issue or deliver policies or certificates outside of Florida which provide coverage to one or more employees or their dependents who are residents of Florida are subject to the requirements of this section. They would also be required to file rates and forms, prior to use, with the department for approval. Currently, these insurers are only required to file forms, but not rates, for informational purposes and some of these insurers are not required to file anything with the department.

This section limits the amount by which a small business carrier may increase its premium rates both between classes of business and within classes of business. It prohibits a small employer carrier from involuntarily transferring a small employer into or out of a class of business. To transfer a small employer, the carrier must offer to transfer all small employers in that class of business without regard to case characteristics, claims experience, health status or duration since issue.

There is a 20 percent cap on the rate difference between classes. Specifically, the index rate (for each class of business for small

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employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate) for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent.

The 20 percent cap does not apply to a class of business if all of the following apply:

1. The class of business is one for which the carrier does not reject, and never has underwritten small employer groups based on claim experience or health status.
2. The carrier does not involuntarily transfer, and has never involuntarily transferred, a health benefit plan into or out of the class of business.
3. The class is currently available for purchase.

Within a single class of business, the premium rate charged to small employers with similar case characteristics for the same or similar coverage may not vary from the index rate (the average rate in the class) by more than plus or minus 25 percent of the index rate. (Note that similar "case characteristics", as defined does not include health characteristics since issue.)

The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

1. The percentage change in the new business premium rate from the first day of the prior rating period to the first day of the new rating period. If the carrier is not issuing new policies, the carrier must use the percentage change in the base premium rate.
2. An adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer.
3. Any adjustment due to change in coverage or change in the case characteristics of the small employer.

For health benefit plans issued prior to the effective date of this act, the premium rate for a rating period may exceed the 20 percent cap between classes and the 25 percent cap within classes, for a period of five years. However, the percentage increase in the premium change in the new business premium rate charged to a small employer in this class of business for a new rating period may not exceed the sum of the 1 and 3 directly above. The limitation of 15 percent due to claim experience, health status or duration of coverage does not apply.

A health benefit plan subject to the provisions of this section may not be cancelled or nonrenewed by the small employer carrier except for the following reasons:

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1. Nonpayment of required premiums.
2. Fraud or misrepresentation of the small employer, insured individual or subscriber or any of their representatives.
3. Noncompliance with plan provisions.
4. The number or percentage of covered persons is less than the required number or percentage under the plan.
5. The small employer is no longer engaged in the business that he was in when he signed up for the policy.

If a small employer carrier ceases to renew all plans under a class of business, the carrier is required to provide notice to all affected plans and to the commissioner in each state that has an affected insured, at least 90 days prior to termination of coverage.

A carrier that chooses to cease renewing all plans in a class of business is prohibited from establishing a new class of business for 5 years without prior approval of the department. The carrier is also prohibited from providing coverage to any of the employers of the nonrenewed class of business unless coverage is provided to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status or duration of coverage.

Each small employer carrier is required to disclose in solicitations and sales materials provided to the small employer the following information:

1. The extent to which premium rates are established or adjusted due to specific underwriting criteria.
2. The provisions relating to the carrier's right to change premium rates.
3. A description of the class of business in which the small employer is or will be included.
4. The provisions relating to renewability of coverage.

The small employer carrier is required to maintain a complete and detailed description of its rating practices and renewal underwriting practices which must be made available to the department upon the department's request. The information will be considered proprietary and trade secret information and shall not be subject to disclosure by the department to anyone outside the department except as agreed to by the carrier or ordered by the court. On March 1 of each year the small employer carrier is also required to file an actuarial certification with the department which indicates compliance with the provisions of this act.

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The department may suspend all or any part of this act upon a filing by the small employer carrier and a finding by the department that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the fairness of the marketplace for small employer health insurance.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 381.702(1), F.S., to include to replace the term "refinancing costs" with "initial financing costs".

Section 2. Amends s. 381.703(3)(b), (c) and (g), F.S., relating to local and state health planning, to establish an annual fee of \$150 for licensed health facilities excluding hospitals, nursing homes and adult congregate living facilities which are assessed based on the number of beds. Also specifies that the fees shall be used to maintain the fiscal year 1990-1991 aggregate funding level for local health councils and the Statewide Health Council plus any increase mandated by the Legislature.

Section 3. Amends s. 381.706(1)(c), F.S., relating to CON review, to exclude refinancing debt from CON review.

Section 4. Amends s. 381.708, F.S., to increase CON filing fees.

Section 5. Amends s. 390.014(3), F.S., to increase licensure fees for abortion clinics.

Section 6. Amends s. 395.004(2), F.S., to increase hospital licensing fees.

Section 7. Amends s. 395.007(2)(a), F.S., to increase fees for the review of hospital plans and construction.

Section 8. Amends s. 400.062(3), F.S., to increase licensure fees for nursing homes.

Section 9. Amends s. 400.23(8), F.S., to increase fees for review of nursing home plans and construction.

Section 10. Amends s. 400.407(4)(a), F.S., to increase licensing fees for an adult congregate living facility.

Section 11. Amends s. 400.418, F.S., to revise or correct a reference.

Section 12. Amends s. 400.467(2), F.S., to increase licensing fees for a home health agency.

Section 13. Amends s. 400.605(2), F.S., to increase licensing fees for a hospice.

Section 14. Amends s. 483.172(5), F.S., to increase licensing fees for a clinical laboratory.

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Section 15. Repeals s. 381.713(1), F.S., which provides an exemption from CON review for certain projects undertaken by an HMO. The repeal is drafted so that it will not affect the outcome of any exemption under the subsection requested of the department before April 17, 1991.

Section 16. Repeals paragraph (a) of subsection (3) of s. 381.706, F.S., which provides an exemption from CON for projects specifically mandated and funded by the Legislature.

Section 17. Amends s. 11.45(a)(3), F.S., to require the Office of the Auditor General, while conducting a performance of any agency, to use the Agency's Functional Plan in the evaluation.

Section 18. Amends s. 20.055(8), F.S., to require the chief internal auditor to monitor the implementation of the agency's response to any agency audit conducted by the Auditor General. Further, the chief internal auditor is required to report to the agency head on the status of corrective action taken, and to file such a report with the Joint Legislative Auditing Committee.

Section 19. Creates s. 216.176, F.S., to require that the Governor's recommended budget contain a "truth in budgeting" statement which shall display in summary form all currently estimated fees, taxes, revenues, or other income which need to be raised to fund the proposed budget and its annualized costs. Further, the "truth in budgeting" statement for the General Appropriations Act shall be completed by the Legislature no later than 72 hours prior to the end of the period authorized by law for veto consideration by the Governor.

Section 20. Amends s. 216.136(3), F.S., to provide that any Revenue Estimating principal, as defined in s. 216.136(3), F.S., may request the Revenue Estimating Conference to review and estimate revenues for any trust fund.

Section 21. Provides legislative intent.

Section 22. Amends s. 383.14, F.S., 1990 Supplement, to expand health screening requirements to include environmental risk factors to identify high-risk pregnant women and infants for enhanced health services. This section requires the Department of Health and Rehabilitative Services to establish and promote a program to screen all pregnant women and infants for environmental risk factors, including income, education, maternal and family stress, substance abuse and other high risk conditions, using a birth-scoring system. The bill requires that screening be conducted by the primary health care provided in hospitals, perinatal centers, county public health units, school health programs that provide prenatal care, and birthing centers. Information is gathered on a risk assessment instrument, developed by the department, and submitted to the Office of Vital Statistics for notification and follow-up enhanced services. This section requires integration with existing information registries and existing programs and services for at-risk families. The program

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remains optional and confidential under existing statute. This section will not go into effect until March 1, 1992.

Section 23. Amends s. 383.011(3), F.S., to direct the department to administer enhanced prenatal and infant health care services through the county public health units or subcontractors for the provision of enhanced services, including case finding or outreach, assessment of health, social, environmental and behavioral risk factors, case management, home visiting and childbirth and parenting education. A Healthy Start Care Coordination Program is created in each county public health unit, specifying the use of family outreach workers to provide the enhanced services. A care coordinator is designated to receive reports, assist health care coalitions and direct outreach efforts. The department is directed to adopt rules to assign certain outreach workers based on the level of risk and to develop procedures for subsequent screenings as well as immunizations in accessible locations. This section also expands pediatric primary care services to low income children in private physicians' offices and physician professional services in hospital settings.

Section 24. Amends s. 383.013(7), F.S., to direct the department to provide level III obstetric outpatient care to women diagnosed as being high risk through regional perinatal intensive care satellite centers. This program merges the expertise of faculty obstetrician consultants, nurses, genetic counselors and nutritionists with local private sector obstetricians and county public health units to deliver specialized high risk obstetric care.

Section 25. Amends s. 383.215(2) and (4), F.S., to direct the department to establish Development, Evaluation, and Intervention programs at stepdown perinatal intensive care centers in addition to those that exist in the Regional Perinatal Intensive Care Centers.

Section 26. Creates s. 383.216, F.S., to direct the department to assist in the establishment of prenatal and infant health care coalitions at the county or district level to provide coordinated community prenatal and infant health care. This section directs each coalition, in coordination with the department and the local health planning councils established under s. 381.703, F.S., to develop a maternal and child health plan for the community, including a needs assessment. It also provides requirements for the plan and specifies the duties of the department, including supervising the functions of the coalitions, and directs the department to retain responsibility for all of the functions delegated to the coalitions in those communities where coalitions do not exist.

This section also provides up to \$150,000 to each prenatal and infant health care coalition that petitions for recognition, meets certain criteria, and provides a local cash or in-kind contribution match of 25 percent of the costs of the coalitions. Additionally, this section authorizes staffing the coalitions and directs the coalitions to incorporate as not-for-profit

organizations. This section also directs the department to adopt rules that are necessary to carry out the provisions of this act.

Section 27. Creates s. 383.2161, F.S., to require the Department of Health and Rehabilitative Services to compile and analyze risk information and coalition findings and prepare an annual report to the Legislature which indicates the number of families served, the unmet need for services and determines program effectiveness.

Section 28. Directs the Department of Health and Rehabilitative Services to develop and submit to the Legislature a plan for decategorizing the budget resources provided to two districts into a single child and maternal health budget. The plan is required to include an alternative reimbursement methodology that rewards those providers who develop social services, educational linkages and support services to enhance maternal and child health care.

Section 29. Amends s. 427.012(1)(k), F.S., to expand the membership of the Transportation Disadvantaged Commission to include one member of the State Coordinating Council for Early Childhood Services, established under chapter 411, F.S.

Section 30. Creates s. 409.901, F.S., and provides definitions for the sections in this bill.

Section 31. Creates s. 409.902, F.S., and designates the Department of Health and Rehabilitative Services as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act.

Section 32. Creates s. 409.903, F.S., and authorizes the department to make payments for medical assistance on behalf of individuals determined by the department to be eligible for Medicaid. This section provides descriptions of the eligibility categories that are mandated by the federal government according to Title XIX of the Social Security Act.

Included in this section is a Healthy Start provision which directs the department to expand Medicaid services to qualified pregnant women and children under 1 year of age from the current standard of 150 percent of the federal poverty level to 185 percent, effective January 1, 1992. In the General Appropriations Act, \$23.1 million was appropriated to fund this expansion for six months in 1991-92.

Section 33. Creates s. 409.904, F.S., and authorizes the department to make payments for medical assistance on behalf of individuals determined by the department to be eligible for Medicaid. This section provides descriptions of the eligibility categories that are considered to be optional by the federal government according to Title XIX of the Social Security Act.

Section 34. Creates s. 409.905, F.S., and authorizes the department to make payments for specified medical and medically-related services which are required by Title XIX of the Social Security Act. These "mandated" services include: advanced

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registered nurse practitioner; early periodic screening, diagnosis, and treatment; family planning; home health services; hospital services; laboratory; skilled level nursing homes; physician; portable x-ray; rural health clinic; and transportation. The section stipulates that payment shall be made for medically necessary services only.

Section 35. Creates s. 409.906, F.S., and authorizes the department to make payments for specified medical and medically-related services which are not required by Title XIX of the Social Security Act. These "optional" services include: adult dentures; adult health screening; ambulatory surgical center services; birth centers; case management; children's dental; chiropractic; community mental health; durable medical equipment; hearing; home and community based services for individuals determined to be in need of nursing home care; hospice; intermediate care facilities for the mentally retarded; intermediate level nursing homes; optometric; podiatric; prescribed drugs; state hospital for psychiatric patients over the age of 65; and visual.

Section 36. Creates s. 409.907, F.S., and directs the department to make payments for medical assistance rendered to Medicaid recipients only to those individuals and organizations which have currently effective provider agreements. This section requires the provider to provide to Medicaid recipients services or goods of not less than the same scope and quality that it provides to the general public. It also provides specific detail about what shall be included in provider agreements. Finally, providers who have been overpaid and who agree with the department on the amount of overpayment may be terminated for non-repayment or partial repayment.

Section 37. Creates s. 409.908, F.S., and directs the department to reimburse Medicaid providers for services rendered in accordance with state and federal law and the methodologies set forth by the department. The reimbursement rates of institutional providers shall be established prospectively based on cost reports, whereas, most non-institutional providers, with the exception of prepaid health plans, shall be reimbursed on a fee-for-service basis. Prepaid health plans shall be compensated on a negotiated, prepaid basis. Certain providers are reimbursed on an all-inclusive rate basis.

As part of the Healthy Start initiative, this section increases the physicians' Medicaid reimbursement rate for obstetrical services from the current level of \$1000 to \$1500 for low risk delivery, and from \$1600 to \$2000 for high risk delivery, effective April 1, 1992. There is an appropriation of \$7.4 million in the General Appropriations Act to fund this increase for three months in 1991-92.

This section also directs the department to establish and implement a Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing homes which insures that reimbursement rates are adequate to cover the costs of an efficiently and economically operated nursing home.

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Section 38. Transfers s. 409.2665, F.S., 1990 Supplement, related to Medicaid third party liability to newly created s. 409.910, F.S., makes minor revisions, and repeals subsection (19) of s. 409.910, F.S. In the 1990 Session, this subsection was intentionally deleted from CS/CS/CS/HB 1209, but was inadvertently left in SB 748.

Section 39. Creates s. 409.911, F.S., and directs the department to distribute moneys appropriated from the Public Medical Assistance Trust Fund to hospitals providing a disproportionate share of hospital services to Medicaid and charity care patients. In the formula, as a hospital's percentage of charity care and Medicaid patient days increases, the disproportionate share payment increases exponentially. An appropriation of \$26.5 million appears in the General Appropriations Act; however, contributions by local governments may increase this amount to \$168 million in 1991-92.

The section also provides definitions related to the disproportionate share program and the formula for distributing the appropriated funds. Further, it authorizes the department to receive funds from local governments and other political subdivisions in order to make payments through the disproportionate share program.

Section 40. Creates s. 409.9112, F.S., and incorporates the disproportionate share program for hospitals participating in the Regional Perinatal Intensive Care Center (RPICC) program into the Medicaid section. In 1991-92, \$6.7 million shall be distributed to the ten RPICC hospitals based on the proportion of Medicaid and charity care services they provide.

Section 41. Creates s. 409.9113, F.S., and replaces the funding of graduate medical education in statutory teaching hospitals from the Medical Education and Tertiary Care Trust Fund with a Medicaid based disproportionate share program for teaching hospitals in order to maximize federal funding. In 1991-92, \$16.6 million shall be distributed to Florida's six teaching hospitals using the same formula as was previously used to distribute moneys from the Medical Education and Tertiary Care Trust Fund.

Section 42. Creates s. 409.9114, F.S., and establishes an extraordinary disproportionate share program for hospitals. In order to qualify for this program, a hospital must either be a teaching hospital or be owned by a hospital district authority and have a ratio of net charity care expenditures to net operating revenues that exceeds 9 percent. The amount that is distributed under this program is dependent upon the amount the qualifying hospitals contribute to this program.

Section 43. Creates s. 409.912, F.S., and directs the department to purchase medical and medically-related goods and services for Medicaid recipients in the most cost effective manner. The section authorizes the department to contract with health maintenance organizations and other public or private entities for

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prepaid health care services. By January 1, 1992, an entity contracting with the department for prepaid health services must maintain an amount equal to its monthly prepaid Medicaid revenues in the form of liquid assets. That surplus amount increases to an amount equal to one and a half times its monthly revenues on January 1, 1993.

This section also authorizes the department to apply for waivers of federal laws and regulations to implement more cost effective health care delivery systems.

Further, the department is directed to establish a post-payment utilization control program to identify recipients who misuse the Medicaid services, to establish incentive systems to encourage the cost effective use of services, and to identify use and price patterns within Medicaid that are not cost effective.

Section 44. Creates s. 409.913, F.S., and directs the department to operate a program that oversees the activities of Medicaid recipients and providers and to insure that fraudulent and abusive behavior is minimized. This section instructs the department to conduct investigations, audits, and analyses of possible fraud.

The section also specifies requirements that must be followed by providers when submitting claims for payment by Medicaid. It provides the length of time that records must be retained by providers and the section stipulates the time periods information obtained during an investigation can be exempt from the public records law.

Finally, the section provides a listing of the circumstances under which the department may impose administrative sanctions against Medicaid providers and a listing of the types of sanctions that may be imposed. It authorizes the department to recover up to \$15,000 in expenditures related to investigations when the department's findings are not contested or when the department prevails in a hearing.

Section 45. Creates s. 409.914, F.S., and authorizes the department to use systems that have been developed for the Medicaid program to assist other entities in programs which provide access to health care for the uninsured and the underinsured.

Section 46. Creates s. 409.915, F.S., and directs the state to charge counties a certain percentage of the Medicaid inpatient hospital and nursing homes costs of Medicaid eligible county residents. This section requires counties to set aside sufficient funds to pay for the costs of care of county residents for whom county contributions are required. Exemptions from this requirement are identified.

Section 47. Creates s. 409.916, F.S., and directs the department to deposit any funds received from pharmaceutical manufacturers or from cost containment strategies into the Grants and Donations Trust Fund. Funds received from pharmaceutical manufacturers are

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to be used to fund the state portion of the Medicaid prescribed drug program; however, at least \$75,000 may be appropriated for Medicaid research and development activities in the General Appropriations Act.

Section 48. Renumbers s. 409.2662, F.S., which establishes the Public Medical Assistance Trust Fund, and creates s. 409.918, F.S. for the purpose of funding health care services for indigent persons. This section appropriates \$30 million annually from the Public Medical Assistance Trust Fund for the establishment and maintenance of primary care programs in the county public health units. It also expands the possible uses of moneys in the Fund to any uses that are specified by law.

Section 49. Creates s. 409.919, F.S., and directs the department to adopt rules that are necessary to carry out the provisions of the act.

Section 50. Creates s. 409.920, F.S., and provides definitions related to Medicaid provider fraud. The section also puts forth the penalties for specific types of fraud related to the Medicaid program and sets a statute of limitations of five years after the cause of action has occurred. In addition, the Auditor General is directed to conduct a statewide program of Medicaid fraud control.

Section 51. This section transfers language from Chapter 90-232, Laws of Florida, which created the Task Force on County Contributions to Medicaid to s. 409.915, F.S., and extends the date by which the Task Force shall provide a report to the Governor and Legislature to February 1, 1992.

Section 52. Directs the department to conduct a study of Florida's Medicaid reimbursement to pharmacy providers and to prepare a report on the adequacy of reimbursement for pharmaceutical ingredients and for the dispensing of prescriptions. The report is due to the Governor and the Legislature by December 15, 1991.

Section 53. This section corrects a cross reference in s. 110.123(3)(d), F.S., 1990 Supplement, the state group insurance program.

Section 54. This section corrects a cross reference in s. 154.011(1), F.S., primary care services.

Section 55. This section corrects a cross reference in s. 394.4787(7), F.S., mental health services.

Section 56. This section corrects a cross reference in s. 395.01465(2), F.S., emergency care services.

Section 57. This section corrects a cross reference in s. 400.126(1)(b), F.S., receivership proceedings.

Section 58. This section corrects a cross reference in s. 400.18(1), F.S., nursing facilities.

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Section 59. This section corrects a cross reference in s. 400.332, F.S., nursing homes.

Section 60. This section corrects a cross reference in s. 407.51(2), F.S., Health Care Cost Containment Board.

Section 61. This section corrects a cross reference in s. 409.2673(6)(c), F.S., 1990 Supplement, shared county and state health care program.

Section 62. This section corrects a cross reference in s. 409.345(10), F.S., public assistance.

Section 63. This section corrects a cross reference in s. 409.701(5)(d), F.S., 1990 Supplement, Small Business Health Access Corporation Act.

Section 64. This section corrects a cross reference in s. 410.036, F.S., aging and adult services.

Section 65. This section corrects a cross reference in s. 624.424(9)(a), F.S., insurance code.

Section 66. This section corrects a cross reference in s. 627.736(4), F.S., insurance rates and contracts.

Section 67. This section corrects a cross reference in s. 631.813, F.S., insurer insolvency.

Section 68. This section corrects a cross reference in s. 641.261(1), F.S., health care service programs (commercial health maintenance organizations).

Section 69. This section corrects a cross reference in s. 641.31(14), F.S., health maintenance organization contracts.

Section 70. This section corrects a cross reference in s. 641.411(1), F.S., health maintenance organization reporting requirements.

Section 71. This section corrects a cross reference in s. 768.73(2)(6), F.S., negligence.

Section 72. Amends subsection (1) of s. 895.02, F.S., to include all Medicaid fraudulent activities described in s. 409.920, F.S., of this act as "racketeering" activities.

Section 73. Reenacts paragraph (g) of subsection (3) of s. 655.50, F.S., for the purpose of incorporating an amendment to s. 895.02, F.S., 1990 Supplement.

Section 74. Reenacts paragraph (g) of subsection (1) of s. 896.101, F.S., for the purpose of incorporating an amendment to s. 895.02, F.S., 1990 Supplement.

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Section 75. Prohibits the department from providing to nursing homes any diagnosis-specific reimbursement that creates a disincentive for terminally ill patients from electing Medicare or Medicaid hospice benefits.

Section 76. Provides that rules adopted by the department prior to October 1, 1991, related to Medicaid statutes which are amended or repealed by this bill shall remain in effect until they are superseded by new rules.

Section 77. Repeals existing statutes and laws related to the Florida Medicaid program.

Section 78. Amends s. 395.0335(2), (3), (5), (6), (8), and (13), F.S., 1990 Supplement, to replace the designation of state-sponsored trauma centers with state-approved trauma centers. This revision clarifies legislative intent that hospitals be state-approved as trauma centers regardless of the availability of state funding.

This section also allows the department, under certain circumstances, to grant additional time for hospital applicants to meet facility, equipment, personnel, and quality assurance requirements if they are not located in an area that has reached its maximum allowable number of state approved trauma centers.

Section 79. Amends s. 395.034, F.S., to provide a definition of a state-approved trauma center and to establish that state-approved trauma centers which receive funding are state-sponsored trauma centers.

The section also requires state-sponsored trauma centers to submit claims electronically using a trauma claims processing system developed by the Medicaid program office.

There is a provision which requires the trauma patient day to be medically necessary in order for the state-sponsored trauma center to be compensated by this program. This provision is in addition to the requirements that the patient meet the definition of charity care and have an injury severity score of 9 or more.

Also, included in this section is the provision that the department pay trauma claims on a monthly basis. In a month in which the claims submitted for a particular trauma region would consume all of the unexpended funds for that region, then the payment of those outstanding claims would be pro-rated.

Finally, this section excludes funds received from the state-sponsored trauma center program from being considered as net revenues in determining whether an excess has occurred in a hospital's allowable rate of increase permitted by the Health Care Cost Containment Board.

Section 80. Amends s. 395.0345, F.S., to expand the uses of funds in the Trauma Services Trust Fund to include the development and support of a system of state-sponsored trauma centers. Previous

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language limited the use of funds to the compensation of trauma centers and the development of a trauma center payment system.

Section 81. Repeals section 14 of chapter 90-284, Laws of Florida, as this provision has been moved to s. 395.034, F.S.

Section 82. Appropriates \$200,000 from the Emergency Medical Services Trust Fund to fund the review team of out-of-state experts that evaluates each provisional trauma center prior to its becoming a state approved trauma center.

Section 83. Amends s. 641.48(3), F.S., to clarify both the financial and non-financial requirements that are necessary to contract with the department for a Medicaid prepaid health plan. Prepaid health plans that enroll only Medicaid recipients are exempt from the requirements of chapter 641 with the exception of s. 641.48, F.S.

Section 84. Amends s. 641.495(10), F.S., to limit the number of HMOs that are exempt from the hospital licensure requirements in part I of chapter 395 to those HMOs that provided 10 or fewer holding beds prior to January 1, 1991. To qualify for this exemption an HMO must also maintain its accreditation. This section also updates and expands the list of acceptable accreditation organizations.

Section 85. Amends s. 641.51, F.S., to remove the requirement that an HMO's quality assurance program include a review by an external review organization once every three years and revises the circumstances under which an HMO subscriber may seek a second opinion. Current law limits second opinions to when the subscriber: 1) disputes the HMO's opinion of necessity of a surgical procedure, or 2) is subject to a life-threatening injury or illness. The new language permits a second opinion when the subscriber questions the HMO's or the physician's opinion of the reasonableness or necessity of a surgical procedure or when the subscriber is subject to a serious injury or illness.

This section permits the subscriber, when seeking a second opinion, to choose: 1) a physician from a list of contracted or employed physicians provided by the HMO, or 2) a non-contract physician who is located in the same geographic area as the HMO.

Section 86. Creates s. 641.511, F.S., to require each HMO to provide the department annually with a report on its grievances and to require the department to investigate all reports of unresolved grievances received either from subscribers directly or from the Department of Insurance. The section also permits the department to investigate any complaints about HMOs at any time. A legitimate grievance related to the quality of health services that is not resolved may be referred to the Statewide Subscriber Assistance Panel for resolution.

Section 87. Creates s. 641.512, F.S., to direct the department to require each HMO to become accredited within one year of receipt of a Certificate of Authority and to maintain its accreditation

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status as a condition of doing business in Florida. Accreditation shall be performed by an accreditation organization with recognized experience in HMO accreditation. The accreditation organization shall be chosen by the individual HMO from an approved list provided by the department. In the event that no accreditation organization can be approved by the department, the department shall require each HMO to have an external quality assurance assessment performed by a review organization approved by the department within one year of receipt of a Certificate of Authority and every two years thereafter. All costs for the review are to be borne by the HMO.

Section 88. Amends s. 641.515, F.S., to require the Department of Health and Rehabilitative Services to investigate any information provided in reports from the Statewide Subscriber Assistance Panel, the accreditation organization, or the review organization, that indicates the HMO does not meet accreditation standards or the standards of the review organization performing the external quality assurance assessment.

The section authorizes the department to have access to subscribers' medical records held both by employed and contracted physicians. It deletes the requirement that the department obtain a subpoena before obtaining a subscriber's medical records.

The department is also directed to adopt rules that establish standards of care for physicians and hospitals performing services for HMOs which are applicable to physicians and hospitals that are not associated with HMOs. In section 123 of CS/CS/HB 2309, the department is authorized to impose administrative fines not to exceed \$2,500 per violation when an HMO fails to comply with the quality of health standards set forth in these rules.

Section 89. Amends s. 641.52(1)(g), F.S., to permit the department to suspend the authority of the HMO to enroll new subscribers or revoke the HMO's Health Care Provider Certificate if the HMO has not maintained its accreditation status or has failed to meet the standards of the review organization performing the external quality assurance assessment.

Section 90. Directs the Health Care Cost Containment Board to conduct a study on competition and provider contracts in health maintenance organizations. A technical advisory board shall be appointed by the board to conduct the study. The board shall prepare a report and submit it to the Governor and the Legislature by December 15, 1991.

Section 91. Re-enacts Chapter 641, Part IV, F.S., as amended by this act until October 1, 2001.

Section 92. Appropriates \$600,000 from the Health Maintenance Organization Quality Care Trust Fund for nine career service positions to implement the provisions of this part of the bill.

Section 93. Amends s. 154.01(5), F.S., to allow the Legislature to authorize funding for construction or expansion projects to

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non-profit primary health care providers who are under contract with the department.

Section 94. Establishes the Florida Health Care Purchasing Cooperative and sets forth its duties and powers. Creates the board of directors and specifies the initial seven members. This section also directs the Health Care Cost Containment Board to provide staff and administrative support to the cooperative board of directors until staff can be hired. Requires that the first meeting of the board be held on or before September 1, 1991.

Section 95. Appropriates \$500,000 for fy 1991-92 and \$500,000 for 1992-93 from the State Employees Disability Trust Fund to the Health Care Cost Containment Board Trust Fund to fund the cooperative.

Section 96. Amends s. 407.50(11)(a), F.S., to exempt hospitals which are licensed for 33 or fewer beds and which operate intensive residential treatment programs for children and adolescents. These hospitals cannot be part of a multifacility organization but they must be part of a community mental health system.

Section 97. Amends s. 186.003(9), F.S., to add the definition of "Statewide Health Council".

Section 98. Amends s. 186.022(2), F.S., to direct the Governor's Office to consider the findings of the Statewide Health Council review of agency functional plans.

Section 99. Amends s. 186.503(7) and (9), F.S., to add the definitions of "local health council" and "Statewide Health Council".

Section 100. Amends s. 186.507(10), F.S., to direct each regional planning council to enter into a memorandum of agreement with each local health council in its comprehensive planning district.

Section 101. Amends s. 186.508(1), F.S., to direct the Executive Office of the Governor to consider the Statewide Health Council's review of comprehensive regional policy plans.

Section 102. Amends s. 186.511, F.S., to direct each regional planning council to involve local health councils in its region in the review of the health element of its plan.

Section 103. Amends s. 187.201(6), F.S., 1990 Supplement, to direct the Legislature to include specific health goals and policies in its State Comprehensive Plan. This section substantially rewords subsection (6) of s. 187.201, F.S., which is the health element of the State Comprehensive Plan. The single health goal in subsection (6) is replaced with four new goals, the number of policies is reduced, and the policies are made more directive.

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Section 104. Amends s. 381.703(1), (2), and (4), F.S., to direct local health councils to develop a schedule for appointing members, and to revise the functions of the local health councils, the membership and functions of the Statewide Health Council, and the duties and responsibilities of the department. This section specifies that the state health plan developed by the Statewide Health Council is to contain sub-goals, quantifiable objectives, strategies and resource requirements to implement the goals and policies of the health element of the State Comprehensive Plan. This section requires district health plans developed by the local health councils to be consistent with the objectives and strategies in the state health plan. This section also requires the Statewide Health Council to review agency functional plans, comprehensive regional policy plans, local government plans, and local health council district health plans for consistency with the health element of the State Comprehensive Plan. This section further requires the Statewide Health Council and local health councils to conduct public forums to discuss the state's health care goals and policies and to develop suggested revisions to the health element of the State Comprehensive Plan.

Section 105. Amends s. 401.291(2), F.S., 1990 Supplement, to authorize an emergency medical services medical director to allow the use of an automatic or semiautomatic defibrillator by an individual who has met certain requirements and who is a member of a locally coordinated response team. These training requirements include certification in CPR, or successful completion of a basic first aid course which includes cardiopulmonary resuscitation training, demonstrated proficiency in the use of an AED, and at least 6 hours of training in the use of an AED.

Section 106. Appropriates \$70,000 from the Local and State Health Trust Fund to the Statewide Health Council for reviewing agency functional plans and other plans.

Section 107. Repeals s. 381.025, F.S., which relates to legislative intent for long range health planning.

Section 108. Creates the Health Care Work Group, a 21 member group appointed by the Governor to make recommendations to the Governor and the Legislature on health care reforms by January 1, 1992. The work group is administratively housed in HRS and staffing for the group is to be provided by HRS.

Section 109. Exempts certain foreign trained dentists from taking a specified training course in order to be licensed as long as they meet all other requirements for licensure.

Section 110. Creates s. 627.4106, F.S., relating to small group health insurance rating reforms (see effects of proposed changes for details).

Section 111. Provides an effective date of upon becoming a law except as otherwise specified in the act.

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### III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

#### A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

##### 1. Non-recurring Effects:

1991-92      1992-93

##### Transfers:

Department of Health and Rehabilitative Services

Sunset Review of Chapter 641, Part IV, HMOs

Study of HMO provider contracts

Health Maintenance Quality Care TF (\$60,000)

Health Care Cost Containment Trust Fund \$60,000

Department of Administration

Health Care Purchasing Cooperative

Administrative Costs

State Employees Disability Trust Fund (\$500,000) (\$500,000)

Health Care Cost Containment Trust Fund \$500,000 \$500,000

1991-92      1992-93

##### Expenditures:

Department of Health and Rehabilitative Services

Trauma

Out-of-state review team

Emergency Medical Services Trust Fund \$200,000

Sunset Review of Chapter 641, Part IV, HMOs

Study of HMO provider contracts

Health Care Cost Containment Trust Fund \$ 30,000

Salaries and benefits \$ 10,000

Other personal services \$ 20,000

Expenses

##### 2. Recurring Effects:

##### Revenues:

Department of Health and Rehabilitative Services

1991-92      1992-93

##### Fee Increases

Certificate of Need Fee Increases \$3,100,000 \$3,100,000

Health Facility Assessment Increases 160,000 160,000

Construction & Plan Review Increases 1,694,691 1,694,691

Health Facility Fee Increases

Abortion Clinics \$ 8,925 \$ 8,295

Hospitals 474,608 474,608

Ambulatory Surgical Centers 62,012 62,012

Nursing Homes	1,272,629	1,272,629
Home Health Agencies	438,000	438,000
Hospice	17,000	17,000
Clinical Laboratories	167,000	167,000
Adult Congregate Living Facilities	429,651	429,651
	<u>\$2,869,825</u>	<u>\$2,869,825</u>

Expenditures:

Department of Health and Rehabilitative Services

	<u>1991-92</u>	<u>1992-93</u>
<u>Healthy Start</u>		
<u>Medicaid</u>		
Medicaid eligibility/185% Poverty (\$10.5m from PMATF, \$12.6m from federal sources)	\$ 23.1m	\$ 46.1m
Physician services/OB fee increase (\$4.1m from PMATF, \$3.4m from federal sources)	\$ 7.4m	\$ 29.8m
<u>Health Services</u>		
Enhanced services for high risk pregnant women and infants ALG-IPO program (G.R.)	\$ 1.9m	\$ 9.5m
<u>Children Medical Services</u>		
Satellite obstetrical clinics or high risk pregnant women G/A-RPICC support services (G.R.)	\$313,296	\$313,296
Pediatric primary care system for infants and children G/A primary care program (G.R.)	\$525,000	\$700,000
Developmental Evaluation and Intervention G/A-Dev Eval/Intervtn serv (G.R.)	\$ 1.5m	\$ 2.0m
<u>Medicaid Statute Revision</u>		
Hospital Inpatient Svcs-Disproportionate Share program (\$12m from PMATF, \$14.5m from federal sources)	\$ 26.5m	
Graduate Medical Education (\$7.6m from G.R., \$9.0m from federal sources)	\$ 16.6m	
G/A-Regional Perinatal Intensive Care Center Disproportionate Share (\$3.0m from G.R., \$3.7m from federal sources)	\$ 6.7m	

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 Salaries, benefits, expenses for  
 9 career service positions \$600,000 \$600,000

Health Care Purchasing Cooperative  
 Administrative costs  
 Health Care Cost Containment Trust Fund \$500,000 \$500,000

Statewide Health Council  
 Administrative costs \$ 70,000 \$ 70,000

3. Long Run Effects Other Than Normal Growth:

Health Care Purchasing Cooperative

A revenue source for the cooperative will need to be established, perhaps a fee paid by cooperative members.

4. Total Revenues and Expenditures:

	<u>1991-92</u>	<u>1992-93</u>
<u>Revenues:</u>		
Department of Health and Rehabilitative Services		
Health Care Cost Containment TF	\$ 560,000	\$ 560,000
Fee Increases		
Planning and Evaluation Trust Fund	\$6,391,887	6,391,887
Local and State Health Trust Fund	160,000	160,000
Nursing Home and Related Facilities TF	1,272,629	1,272,629

- \* The total revenue generated by the bill will be distributed to the Department of Health and Rehabilitative Services, less a 7 percent service charge assessed, generating approximately \$547,716 to be deposited in the General Revenue Fund.

Expenditures:

Department of Health and Rehabilitative Services

Healthy Start	\$ 4.2m	\$ 5.5m
General Revenue Fund	\$ 14.6m	\$ 34.6m
Public Medical Assistance Trust Fund	\$ 22.9m	\$ 48.3m
Other Trust Funds		

Medicaid Statute Revision	\$ 10.6m
General Revenue Fund	\$ 12.0m
Public Medical Assistance Trust Fund	\$ 27.2m
Medical Care Trust Fund	

Trauma	
Emergency Medical Services Trust Fund	\$200,000

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Health Care Cost Containment Trust Fund	\$ 60,000		
Health Maintenance Org. Quality TF	\$600,000	\$600,000	
Health Care Purchasing Cooperative			
Health Care Cost Containment Trust Fund	\$500,000	\$500,000	
	<u>1990-91</u>	<u>1991-92</u>	
Statewide Health Council			
Local and State Health Trust Fund	\$ 70,000	\$ 70,000	

## B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

## Healthy Start

Enhanced prenatal and postpartum care which includes case finding, home visits, and postpartum care should improve pregnancy outcomes, reduce infant mortality, and reduce uncompensated care losses at government-owned and voluntary hospitals. The exact savings have not been determined.

As prenatal and infant care coalitions develop in communities, improved prenatal and infant health care services will result in improved pregnancy outcomes which should lower uncompensated care losses in government-owned and voluntary hospitals. The exact savings have not been determined.

Merging the expertise of faculty obstetrician consultants with local obstetricians and county public health unit staff in satellite RPICC high risk obstetric clinics to deliver specialized high risk prenatal and obstetric care should reduce the incidence of low birth weight babies and infant mortality in those counties where these services are provided. This should reduce uncompensated care losses at government-owned and voluntary hospitals. The exact savings have not been determined.

Mainstreaming Medicaid eligible and low income children with private sector patients in expanded pediatric primary care programs should provide increased access to private physician services and ease the patient care burden at the county public health units.

## Health Care Purchasing Cooperative

Local governments may participate in the cooperative at their option.

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3. Long Run Effects Other Than Normal Growth:

Health Care Purchasing Cooperative

If a membership fee is established, local governments which choose to participate will be required to pay this fee.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

Health Facility Fee Increases and Certificate of Need Revisions

Health care providers who anticipated using the exemptions from the CON program repealed by this bill will be required to go through the CON process.

Sunset Review of Chapter 641, Part IV, HMOs

HMOs will be required to pay for the accreditation or external quality assurance reviews. The cost of accreditation or an external quality assurance review varies widely, but some can approach \$20,000. For those HMOs which currently have standards that would not meet those required for accreditation, there may be additional costs incurred to come into compliance.

The bill permits a subscriber to obtain a second medical opinion when that person is subject to a serious medical injury or illness. As this is a lower threshold than "life-threatening" which exists in current law, HMOs may experience some increase in costs related to second medical opinions.

Health Care Purchasing Cooperative

There should be none at first. If the cooperative meets its objective, payments by public agencies for medical care may be reduced.

2. Direct Private Sector Benefits:

Health Facility Fee Increases and Certificate of Need Revisions

All health care providers will be more equitably treated by the CON law. Providers will be able to avoid the cost of a CON review for the projects which have been exempted from CON review.

Healthy Start

Expanding Medicaid to 185 percent and obstetric fee increases will bring in an additional \$75.9 million into the health care delivery system. Expanded pediatric primary care services will provide an additional \$7.8 million in state dollars to those private physicians who serve low income children. Increased developmental, evaluation and intervention services will provide an additional \$7.8 million in state dollars.

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#### Medicaid Statute Revision

Indeterminate.

#### Sunset- Review of Chapter 641, Part IV, HMOs

The 1.5 million HMO subscribers in the State of Florida should have greater assurance that the quality of health services they are receiving meets that of their community.

#### Health Care Purchasing Cooperative

Those providers which are identified as efficient providers by the cooperative would receive increased business with governmental entities.

### 3. Effects on Competition, Private Enterprise and Employment Markets:

#### Sunset Review of Chapter 641, Part IV, HMOs

The costs of the external quality assurance review by the most expensive accreditation organizations and the costs of additional second medical opinions may be burdensome to the smallest HMOs in the state which will put them at a disadvantage in a market that is already competitive.

### D. FISCAL COMMENTS:

#### Healthy Start

The expenditures proposed in this analysis are based on the costs as calculated in the Governor's recommended budget for the 1991-1992 fiscal year.

#### Sunset Review of Chapter 641, Part IV, HMOs

The examinations that are to be conducted by the Department of Health and Rehabilitative Services are supported by fees collected from the HMOs for Health Care Provider Certificate renewals and regulatory assessments on gross premiums.

The study on HMO provider contracts is funded from the Health Care Cost Containment Trust Fund.

#### Health Care Purchasing Cooperative

According to the findings and recommendations listed in the report prepared by the HCCB on Pooling State and Local Government Purchasing of Health Care, January 31, 1991, (page 22), "pooled purchasing efforts by private employers have shown the ability to reduce costs to participating employers. Models developed using Florida data showed savings ranging from 1.95 percent to 39.41 percent. These results yield a potential minimum savings of \$30 million in employee benefit costs alone."

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IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

The provisions in this bill should not require counties and municipalities, in the aggregate, to expend funds over the next five to ten years.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

V. COMMENTS:

**Healthy Start**

Unless Florida is successful in finding some fiscal relief, it appears unlikely the state will meet the nation's Health Objectives for the Year 2000. In fact, of the 226 measurable objectives set in 1980, about half have been fully achieved. Florida lags behind in the areas of maternal and child health and indigent care--a recent study estimates that 28% of Florida's infants are at risk to develop handicaps or learning problems, and about half of those will not get adequate help. There is consensus that early maternal, prenatal, and pediatric care improve health outcome, thereby reducing long term, more expensive health care. The expansion in Medicaid coverage and the new revenue sources included in this bill will enable Florida to provide health care to its indigent citizens in a way that maximizes federal financial participation and should provide greater efficiency in Medicaid reimbursement to hospitals and physicians.

**Medicaid Statute Revision**

The bill contains many, very specific provisions which may require frequent amendments to comply with constantly evolving federal laws and regulations.

**Trauma**

This bill clarifies existing statutory language to facilitate the implementation of the state-sponsored trauma center program in the event funding becomes available.

**Sunset Review of Chapter 641, Part IV, HMOs**

Since 1988, the Department of Health and Rehabilitative Services has taken a total of 9 actions against HMOs under the authority granted to the department in Chapter 641, Part IV. During the same time period, a total of 7,068 complaints have been registered with the Department of Insurance and the federal Health Care Financing Administration against one Florida HMO alone. Newspapers increasingly document complaints that subscribers have against HMOs concerning poor care or inadequate treatment. This evidence suggests

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that, at a minimum, there is a need for the Department of Health and Rehabilitative Services to have access to medical records and for greater external oversight of HMO operations.

#### Health Care Purchasing Cooperative

This legislation does offer the potential for state and local governments to save money on health care expenditures through participation in the cooperative. However, any savings would likely not occur for at least a year until the cooperative has an opportunity to collect and analyze data.

This legislation may result in increased health care costs to those who do not participate in the cooperative through forcing private providers of health care services to shift the discounts given to cooperative members to nonmembers.

#### Bill History - CS/CS/SB 1000

- 3/27/91 Senate Health and Rehabilitative Services Subcommittee on Health Care: Favorable as CS; Senate Health and Rehabilitative Services Committee: Favorable as CS (combines this bill and 1234 & 2158)
- 4/02/91 Withdrawn from Senate Appropriations
- 4/03/91 Senate Finance, Taxation and Claims: Favorable as CS/CS
- 4/04/91 (Senate) Placed on Special Order Calendar; amendments adopted; amendments failed; CS passed as amended; Yeas 39 Nays 0
- 4/22/91 House Finance & Taxation: Favorable with 2 amendments
- 4/25/91 Withdrawn from House Appropriations
- 5/01/91 (House) Amendments adopted; CS passed as amended; Yeas 65 Nays 46
- 5/01/91 (Senate) Amendments to House amendments adopted; concurred in House amendments as amended; requested House to concur; CS passed as amended; Yeas 39 Nays 0
- 5/02/91 (House) Concurred; CS passed as amended; Yeas 67 Nays 43

#### VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

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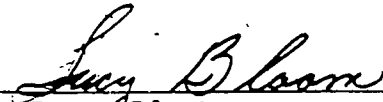
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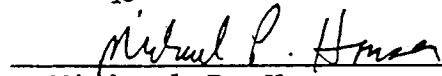
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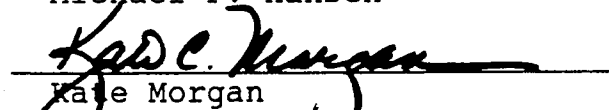
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